

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Spravato[®] (esketamine) (S0013)

Mark the benefit you would like the PA entered under:

- Pharmacy Benefit
- Medical Buy and Bill – submit prior authorization request via fax to pharmacy **1-844-668-1550**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limit:

- Major Depressive Disorder with Acute Suicidal Ideation or Behavior: 8 kits/month; 1 month of treatment
- Treatment-Resistant Depression: 4 kits/month (*induction dose requires 8 kits/month)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

Choose **ONE** of the following applicable diagnoses below. **Provider Please Note:** Any indication that is **NOT** FDA approved will be considered experimental/investigational and **NOT** medically necessary

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Treatment Resistant Depression. ALL the following criteria must be met:

Reauthorization is NOT required

- Member must be 18 years of age or older
 - Spravato[®] must be prescribed by **ONE** of the following:
 - Psychiatrist
 - Provider who has consulted with a psychiatrist (include name/date): _____
 - Member must have a diagnosis of treatment resistant depression (TRD) without psychotic features defined by current DSM criteria made or verified by a psychiatrist
 - ICD Code/Diagnosis:** _____
 - Member must be experiencing moderate to severe symptomology documented by a standardized rating scale that reliably measures depressive symptoms. **A current baseline (within previous 30 days, prior to starting Spravato[®]) scale with scoring must be attached.**
 - Scale:** _____
 - Date Administered:** _____
 - Member must have experienced clinical failure or intolerance with at least two (2) antidepressant therapies from at least two (2) different drug classes (**verified by pharmacy paid claims and/or chart notes**)
 - Failures must be of adequate dose (maximally tolerated)
 - Failures must be of adequate duration (at least 6 weeks)
 - Adherent fills required (verified by pharmacy claims)
 - Failures must occur during current depressive episode
 - Antidepressant therapy would include any of the following classes:
 - Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, paroxetine, sertraline)
 - Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
 - Bupropion
 - Tricyclic antidepressants (e.g., amitriptyline, clomipramine, nortriptyline)
 - Mirtazapine
 - Monoamine oxidase inhibitors (e.g., selegiline, tranylcypromine)
 - Serotonin modulators (e.g., nefazodone, trazodone)
1. **Drug:** _____ **Dose:** _____ **Duration:** _____
Reason for Discontinuation: _____
2. **Drug:** _____ **Dose:** _____ **Duration:** _____
Reason for Discontinuation: _____

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- Member must have experienced clinical failure or intolerance with at least one (1) augmentation therapy (e.g., lithium, liothyronine, antipsychotics or anticonvulsants) (**verified by pharmacy paid claims and/or chart notes**)
 - Failures must be of adequate dose (maximally tolerated)
 - Failures must be of adequate duration (at least 6 weeks)
 - Adherent fills required (verified by pharmacy claims)
 - Failures must occur during current depressive episode
- 1. **Drug:** _____ **Dose:** _____ **Duration:** _____
Reason for Discontinuation: _____
- 2. **Drug:** _____ **Dose:** _____ **Duration:** _____
Reason for Discontinuation: _____
- Spravato[®] must be used in combination with a daily oral antidepressant. **Documentation (pharmacy claims or chart notes) required.**
 - Drug:** _____
- Member does **NOT** have aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels), arteriovenous malformation, or a history of intracerebral hemorrhage
- Prescriber must have assessed the member's risk for abuse of controlled substances (i.e., review of medical history, review of state prescription monitoring program (PMP))
- Member must be enrolled in the Spravato[®] REMS program
- Administering site/provider must be certified in the Spravato[®] REMS program:
 - Name/Location of Administering Provider:** _____

Diagnosis: Major Depressive Disorder with Suicidal Ideation or Behavior

Continuation of inpatient Spravato[®] therapy, ALL the following criteria must be met:

**One-time authorization per episode for remaining doses required for continuation.
Maximum allowable duration = 1 month**

- Provider **MUST** submit date of therapy initiation and number of doses administered up to point of request
 - Date Spravato[®] therapy initiated:** _____
 - Number of doses administered since initiation:** _____
- Member must be 18 years of age or older

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